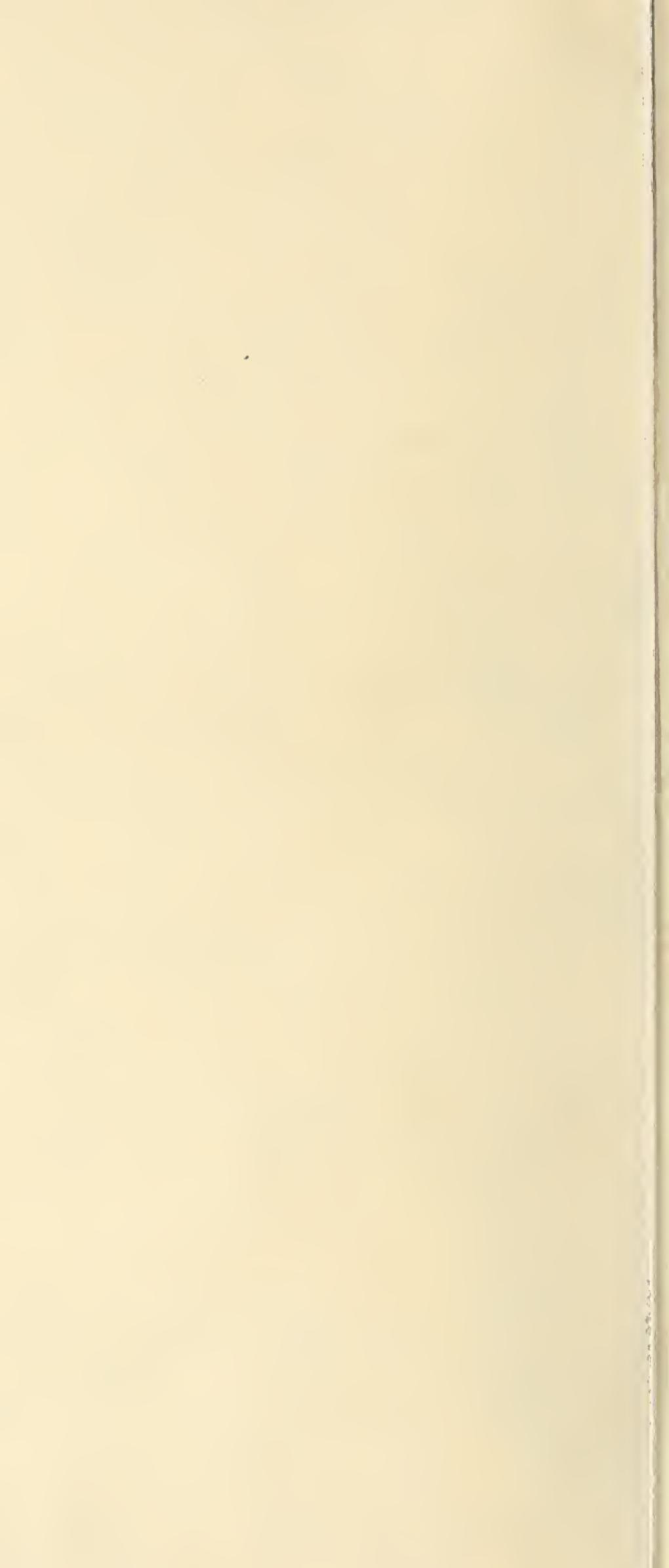


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Payment under Medicare medical insurance



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Payment under Medicare medical insurance

Medicare medical insurance helps pay for a wide range of health care services and supplies that your doctor may prescribe for you. It covers doctors' medical and surgical services, outpatient hospital services, outpatient physical therapy and speech pathology services, durable medical equipment, services from independent laboratories, ambulance services, home health care, and a number of other health services and supplies.

Medicare medical insurance does *not* pay for all health care services. For example, it does not pay for routine physical checkups, routine eye or hearing examinations and eyeglasses or hearing aids, routine dental care and dentures, or prescription drugs or other medicines you buy yourself.

How much medical insurance pays

There is a basic payment rule for services and supplies covered by Medicare medical insurance. Each year, as soon as you have \$60 (the annual deductible) in reasonable charges for covered services, medical insurance will pay 80 percent of the reasonable charges for any other covered services you receive during the rest of the year. (Reasonable charges are explained on page 7.)

There are some exceptions to the basic payment rule. The exceptions are:

- While you are an inpatient in a qualified hospital, medical insurance pays 100 percent of the reasonable charges for services by doctors in the fields of radiology and pathology. Medical insurance pays for these services even if you have not met the \$60 annual deductible. Charges

for these services, however, cannot count toward the deductible.

- Medical insurance pays 100 percent of the reasonable charges for covered home health care. But you must meet the \$60 deductible *before* medical insurance can pay for this care.
- Doctors' services you receive for outpatient treatment of mental illness are covered under a special payment rule. The maximum amount medical insurance can pay for these services is \$250 a year. However, the medical insurance payment could be less than \$250 if charges for these services are used to make up part or all of your \$60 deductible.
- The maximum amount medical insurance can pay for home and office services from a licensed and certified physical therapist in independent practice is \$80 a year. However, the medical insurance payment could be less than \$80 if charges for these services are used to make up part or all of your \$60 deductible.

The two payment methods

There are two ways payments are made for services and supplies covered by Medicare medical insurance. The medical insurance payment can be made to the doctor or supplier. This payment method is called assignment. Or, the medical insurance payment can be made to you, either before or after you pay the bill.

The assignment method can be used *only* if you and the doctor or supplier agree to it. When your doctor or supplier is willing to use the assignment method, he or she must accept the Medicare reasonable charge as his or her total

charge. Medical insurance pays your doctor or supplier 80 percent of the reasonable charge after subtracting any part of the annual \$60 deductible you have not met. The doctor or supplier can charge you *only* for the part of the deductible not met and for the remaining 20 percent of the reasonable charge. Of course, your doctor or supplier also can charge you for any services or supplies that Medicare does not cover.

In the payment-to-you method, medical insurance pays you 80 percent of the reasonable charge after subtracting any part of the \$60 annual deductible you haven't met. Under this method of payment, the doctor or supplier does not have to accept the Medicare reasonable charge as his or her total charge. This means the doctor or supplier can bill you for his or her actual charge, even if it is more than the Medicare reasonable charge. So, you may want to find out in advance whether the doctor or supplier is willing to use the assignment method which limits the doctor's or supplier's total charge to the Medicare reasonable charge.

How to submit claims

To get Medicare medical insurance payments, a *Request for Medicare Payment* form (also called form SSA-1490) must be filled out and sent to the Medicare carrier. The carrier is an insurance company selected by the Federal Government to handle medical insurance payments. The *Request for Medicare Payment* form is available at any social security office, and many doctors and suppliers have copies of it. The leaflet *How to complete the Request for Medicare Payment* also is available at social security offices.

It gives detailed instructions for completing the form.

Assignment—When you and your doctor or supplier agree to use the assignment payment method, you complete Part I of the *Request for Medicare Payment* form and sign it. The doctor or supplier may help you complete Part I or fill it in for you. Then, the doctor or supplier fills in Part II and sends in the form.

If you receive services or supplies covered by medical insurance from a hospital, skilled nursing facility, home health agency, or other health care facility that participates in Medicare, the facility will always submit the claim for the medical insurance payment. The facility can bill you *only* for any part of the \$60 deductible you have not met and for the remaining 20 percent of the reasonable charge. Of course, the facility also can bill you for any services that are not covered by Medicare.

Payment-to-you—When you are submitting the claim, you complete Part I of the *Request for Medicare Payment* form and sign it. The doctor or supplier may help you. Then, ask the doctor or supplier either to fill in Part II or to give you an itemized bill. The bill must show a description of each service; the date, place, and charge for each service; and the doctor or supplier who provided each service. It also must show your name and health insurance claim number including the letter at the end just as they're shown on your Medicare card.

You can send in several bills from one doctor or supplier, or bills from different doctors and suppliers with the same *Request for Medicare Payment* form. And, you can send in the bills either before or after you pay them.

Always be sure that all questions on the form are answered and that you have signed your name.

It's a good idea to keep a record of each claim you submit in case you want to inquire about it. Before you send it in, write down the date you put on the form, each service or supply you received, the date and charge for each service or supply, and the name of the doctor or supplier who provided each service or supply.

Then, send the form—either with your bills or with Part II filled in by your doctor or supplier—to the Medicare carrier for the area where you received the services or supplies. Your Medicare Handbook lists all carrier addresses and the geographic areas for which they are responsible.

Each time you or your doctor or supplier sends in a claim, the carrier will send you a notice explaining the decision and amount of medical insurance payment for each service or supply you received. Please examine the notice carefully. If you think payment was made for a service or supply you didn't receive, or if the payment is otherwise questionable, report it to the carrier that sent you the notice or to a social security office.

When to submit claims

Since Medicare medical insurance payments can't be made until you have met the annual deductible, you should wait until your medical expenses for the year total at least \$60 before you send in a claim.

In determining when your covered expenses total \$60, be sure to count any bills that your doctor or supplier has al-

ready sent in under the assignment method. Also, you should take into account the carry-over rule. Under this rule, any covered expenses you had in the last 3 months of the previous year that counted toward that year's deductible also can be credited toward the current year's deductible.

Once you have met the deductible, we suggest that you send in a claim each time you receive covered services or supplies during the rest of the year. You'll get paid sooner that way.

There are certain time limits on claiming medical insurance payments. If you don't send in a claim within these time limits, medical insurance cannot pay for your covered services and supplies. The time limits are:

- For services you received between October 1, 1975, and September 30, 1976, you must send in your claim by December 31, 1977.
- For services you receive between October 1, 1976, and September 30, 1977, you must send in your claim by December 31, 1978.

Don't send in bills for services you received before the date your medical insurance protection started. This date is shown on your Medicare card.

What are reasonable charges?

Medicare medical insurance takes into account that charges for medical services and supplies will vary from one doctor or supplier to another and that charges also will vary from one geographic area to another. Consequently, instead of basing payments on fixed amounts for particular services and supplies, the Medicare law requires medical insurance to pay for

covered services and supplies on the basis of reasonable charges.

Each Medicare carrier determines the reasonable charges for covered services and supplies for the geographic area in which it is located. At the beginning of each year, the carrier reviews the actual charges made by the doctors and suppliers in its area during the previous year. Based on this review, new reasonable charges are put into effect about July 1 of each year.

Here's how reasonable charges are figured.

First, the carrier determines each doctor's or supplier's *customary* charge for each service or supply furnished to patients in the previous calendar year. The customary charge is generally the charge most frequently made.

Next, the carrier determines the *prevailing* charge for each covered service and supply. The prevailing charge is the amount which is high enough to cover the customary charges in three out of four bills submitted in the previous year for each service and supply. Increases in prevailing charges, however, are limited from year to year by an "economic index" formula which relates increases in doctors' charges to the actual increases in the costs of maintaining their practices and to raises in general earnings levels.

Then, when a claim for medical insurance payment is submitted, the carrier compares the actual charge on the claim with the customary and prevailing charges for that service or supply. The reasonable charge approved by the carrier will be either the customary charge, the prevailing charge, or the actual charge, whichever is lowest.

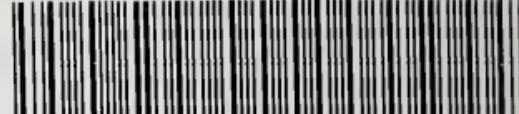
This method of determining reasonable charges does not establish the amounts a doctor or supplier may charge a patient. It only determines the amounts on which Medicare must base its payments.

If the actual charge by your doctor or supplier is higher than the reasonable charge, this does not necessarily mean that his or her charge is unreasonable. Usually, when the Medicare reasonable charge is lower than the actual charge, it's because your doctor or supplier recently raised his or her charges and the new charges have not been in effect long enough to be included in Medicare's annual review of actual charges. Of course, the actual amount billed may be more than the reasonable charge because the doctor or supplier has a higher charge for the particular service or supply than most other doctors or suppliers in your area. Or, if it is a doctor's bill and the reasonable charge is less than the actual charge, it could be because the doctors in your area have increased some of their charges by larger amounts than Medicare can recognize under the "economic index" formula in the law.

For more information

More detailed information about Medicare can be found in *Your Medicare Handbook*. If you don't have one, you can get one at any social security office. The people there also will be glad to help you if you need assistance in claiming medical insurance payments.

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